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PUBLICITY SECTION.

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ERRATA :—Pages 1 to 20 of Vol. IV, No. 2 should be numbered 19 to 38 serially.

"AS the Secretary of a medical organisation with a great experience in these matters, I would, with all my force, urge similar medical organizations throughout the world not to shut their eyes to the developments that are going on and not to leave the politician to find the answer to the problem 'how are we to ensure that our working population can get the medical attendance it deserves on terms which it can afford, and in a way which a self-respecting citizen, not desiring charity, can accept'."

ALFRED COX, M. D.,

Medical Secretary,

British Medical Association, 1931.

BULLETIN

OF THE

SOUTH INDIAN MEDICAL ASSOCIATION.

MARCH 1932.

A few words on Venereal Diseases.*

By. Dr. W. H. Happer, M.D., M.R.C.P.,

Late Venereal Surgeon, Madras General Hospital.

There is no branch of medicine or surgery in which more interesting, varied or important conditions are to be found than in the venereal diseases. The object of this paper is to emphasise the important points, to explain the points where difficulty is likely to be met and to suggest certain differences from the text-book descriptions of these diseases as seen in the West.

Beginning with Syphilis, the first point to be considered is the incidence amongst the community. In the past, this has been much exaggerated. In 15,000 cases sent to the Special Department over a period of 18 months, the incidence of Syphilis was found to be 20 per cent and I would remind you that these are picked cases and not the ordinary hospital population. If the total number of cases of Syphilis is compared with the total number of patients attending the hospital, it would be found that the percentage of Syphilis amounts to 2·2. This figure is much too low and suggests that a consideraale amount of Syphilis is unrecognised. My own belief is that not more than 15 per cent of the population is infected. This is only a guess and I have no figures to prove it; but, I feel that 15 per cent is the absolute maximum of infection in the Madras City and in rural areas it is considerably less.

The next point of interest is the stage at which the cases are seen. The figures for the Special Department show that only 13 per cent reported during the primary stage, 60 per cent in the secondary stage and 27 per cent in the later stages. I need not emphasise that the ideal time to diagnose the condition both from the point of view of treatment and prognosis is in the primary stage, *i.e.*, before the spirochaetes have become disseminated throughout the patient's tissues. The figures I have just given show that only 13 per cent were in this stage and that in 87 per cent the disease was generalized. This suggests that the public is unaware of the importance of genital sores and demonstrates the need for propaganda.

The diagnosis of Syphilis may be easy or difficult depending on the stage at which the patient reports. In diagnosing any condition, one depends on the history, clinical examination, the bacteriological and serological examinations. In the venereal cases, the history is often vague and not always dependable. Clinical diagnosis of a primary sore as seen in the hospital population is almost impossible. The sore is altered in appearance and in 'feel' by a combination of sepsis and native applications. One is therefore dependent entirely on what after all is the only true evidence of the infection at this stage, namely, the demonstration of the spirchaetes. It has become the routine practice in the Special Department to make dark-ground examinations of every genital sore after preliminary dressing with

* Dr. Happer had kindly promised to read this paper before the Union but was unable to do so owing to his departure from Madras.

normal saline. Our figures show that one in every three sores is syphilitic. The general practitioner may not have the dark-ground illuminating apparatus. Scrapings from the sore stained by Fontana's Silver stain give almost as good results and can easily be carried out by the practitioner. The Wasserman at this stage is negative so that the demonstration of the spirochaetes is the only evidence of infection. Unfortunately, in many cases, the medical man diagnoses the sore by what he is pleased to consider the therapeutic test, *i.e.*, the patient is given some anti-syphilitic injections and if the sore shows signs of improvement, it is diagnosed "SYPHILIS". Even when this is adopted, neither the doctor nor the patient knows what the diagnosis is and a few injections only are given which are useless if the case is not Syphilis and dangerous if it is. I would remind you that the badly treated or inadequately treated case of Syphilis runs a greater risk of late and serious complications than the untreated case. The point I want to make therefore is that the only certain evidence of primary syphilitic infection is the demonstration of the Spirochaetae Pallida.

The diagnosis of the acute secondary cases is easy. It depends on the presence of, or history of a sore, adenitis, skin eruptions and mucous membrane lesions. Adenitis is seldom generalized and here a word of warning is necessary. There seems to be a strong impression that enlargement of the epitrochlear glands means Syphilis, while the absence of any enlargement means no Syphilis. Both of these assumptions are very far from being true. Many conditions will cause enlargement of the epitrochlear glands and septic scabies is especially common in this country. On the other hand I see scores of cases of Syphilis in whom there is no such enlargement. The skin eruptions vary, but, the common papulo-squamous one is unmistakable. It has a very strong tendency to become annular especially about the face and the neck. Lesions of the mucous membranes are extremely rare and in this respect Syphilis differs from that seen in Europe where throat and mouth lesions are common. General or constitutional symptoms in the acute secondary stage are common and very often severe and in this respect differs from the Syphilis seen in Europe where the constitutional symptoms are not so marked. It is practically the rule here for the secondary syphilitic to complain of pains in the bones and joints, sometimes, of a very severe character. At this stage the Wassermann is strongly positive. The diagnosis of secondary Syphilis is therefore fairly easy.

In the later stages, the most striking feature is the frequency of bone affections, chiefly, Osteoperiostitis. Any bone may be affected, but the common ones are tibia, femur, clavicle, radius and ulna. Gummatous destruction of the skin, palate and nasal structures are also fairly common. Central nervous disease, *i. e.*, general paralysis of the insane and locomotor ataxia are rare. Various nerve conditions, especially of the 7th nerve and of the nerves supplying the muscles of the eye are seen together with Hemiplegia or Paraplegia. These are however, usually, the result of vascular disease and not of syphilitic destruction of the Parenchyma of the central nervous system. Very little congenital disease is seen in the General Hospital clinic, only 38 in 1929, the great majority of whom were small infants. In the older children, most of the active manifestations seem to occur in the eye. I understand that a considerable number of cases of congenital Syphilis are seen in the Government Ophthalmic Hospital.

No attempt will be made to discuss the treatment of Syphilis beyond saying that it has been unsatisfactory due to the failure of patients to continue treatment for sufficient period. The duty of a medical man does not end with his giving a few injections. It is of the utmost importance to impress upon the patients the necessity for prolonged treatment long after the clinical signs of the disease have disappeared.

Gonorrhoea.—Gonorrhoea is extremely prevalent, but fortunately, the disease is milder amongst Indians than amongst Europeans. This is shown by the fact that complications are not so common amongst Indians and that the disease is more amenable to treatment. This may be due to (1) a higher resistance to gonococcal infection in Indians and (2) a less virulent strain of gonococcus. Proof that it is not of a less virulent strain is seen in the fact that the European gets the disease as badly here as in England and is much more difficult to cure than the Indian. The diagnosis in the acute case is easy and depends on the recognition of the infecting organism.

It is doubtful if any disease is treated so badly as Gonorrhoea is. Countless preparations have been introduced and tried, but, none of them have helped to reduce the duration of the disease by a single day. The whole difficulty can be ascribed to the ignorance of the average medical practitioner as to what is happening during an attack of Gonorrhoea.

During the acute early stage when the patient has a profuse discharge, very little can be done in the way of active treatment. General directions as to the regulation of diet, the intake of fluids, the prohibition of alcohol, the prevention of constipation and the necessity of rest and cleanliness serve to make the patient's life more comfortable and prevent further extension and complications.

It is as well at this stage to consider what is happening. The disease starts as an acute inflammation of the surface of the anterior urethra. In any thing from 60 to 90 per cent of cases, it spreads to involve the surface of the posterior urethra. If this were all that happened, then, the treatment of Gonorrhoea would be simple. The natural arrangement of the male urethra as regards drainage, the constant passage of urine and consequuent cleansing of the urethra and the local, and to some extent, general reaction of the tissues to infection would all help to overcome the infection. Further the ease with which anti-septics can be applied to the surface of the urethra by the irrigation method would complete the eradication of the disease. Unfortunately, the infection extends beyond the surface of the urethra and involves small mucous glands lining the anterior urethra in every case and the prostatic ducts and glands and other side tracks opening off the posterior urethra in most cases. Failure to recognise and treat this deeper infection is the cause of chronicity and relapse in Gonorrhoea.

Treatment of these deeper foci cannot be undertaken until the acute surface infection has settled down. During the acute stage, treatment consists of gentle urethral irrigation by the gravity method with a weak antiseptic solution. The guide to further treatment is the condition of the patient's urine. So long as there is any inflammatory condition on the surface of the urethra, the patient's urine will be turbid owing to the presence in it of products of this inflammation. Ultimately, the urine becomes clear, but, contains many threads. This means that the acute

surface infection is over, but, the threads consist of plugs of pus and glandular secretion from the ducts of these numerous infected side tracks. It is useless to expect the anti-septic to penetrate the glands and their ducts and destory the gonococci in them No anti-septic has this power of penetration. Further, none of the glands either in the anterior or in the posterior urethra have the power of freeing themselves of the infection spontaneously. Treatment therefore becomes mechanical. For the glandular infection of the anterior urethra, dilatation is necessary to stretch the openings of these glands and so enable them to discharge their infected contents. Massage of these glands or follicles on the dilating bougie is of great value in assisting to empty them. This simple procedure should be observed in every case of Gonorrhoea and it will be found that very few applications of the instrument are necessary to produce the desired effect. And even more important procedure is that of prostatic and vesicular massage. Practically every case of posterior involvement of the urethra suffers some infection of the prostate and vesicles. These structures are devoid of any natural drainage apparatus and must be emptied mechanically. A combination of prostatic and vesicular massage and dilatation of the urethra are necessary in most cases to ensure cure.

Complications are not very common. The treatment, when they do occur, is symptomatic plus the treatment of the original urethral focus. Vaccines have been widely employed in the treatment of Gonorrhœa, but the results have been on the whole disappointing. In the acute early case, all that can be hoped for from the vaccine treatment is a reduction in the incidence of complications. It is very doubtful whether the duration of the disease is lessened by their use. In the more chronic cases and in complications, vaccines are definitely of value, particularly, a stock gonococcal vaccine combined with an autogenous vaccine of the patient's own organisms. Various antiseptics given by intravenous injection, such as Acriflavin and Mercurochrome have been advocated. These substances were tried on a fairly large scale in the Special Department, but, they have been given up as being of little value.

It is impossible in this short paper to do more than make a few suggestions on the points where difficulties are likely to arise. For that reason emphasis is laid on the need for early diagnosis and prompt and prolonged treatment of Syphilis. In Gonorrhœa, the importance of realising that it must be treated like any septic surgical condition, namely, the establishment of a good drainage. No substances given either by mouth or by injection are able to destory gonococci in the glands lining the urethra and unless mechanical manipulations are instituted, chronicity and relapse will occur with consequent worry both to the patient and the doctor.

Health and Disease in Relation to Childhood

A. Lecture by Dr. Muthu

Dr. Muthu emphasised the great importance of looking after the child's health which should come even before its education. A nation's greatest asset, he said, was its greatest number of strong and healthy children. Good nurture to-day meant strong heredity to-morrow. A healthy environment created a healthy soil, were micro-organisms or disease could not grow. The soil was more important than

the seed. The seeds of disease took their root in childhood. Of all the environmental factors that went to make a child's soil, nutrition took the largest share. In fact, the problem of a child's well-being was the problem of its nutrition. The people who were best nourished and lived in sanitary surroundings were those who showed the lowest incidence and mortality from disease. Poverty and low vitality of a woman left an indelible mark on the physique of the children born to such a woman. Inadequate and faulty food dulled the brain, impaired the memory and made the child unfit to do justice to its school and college work. In all diseased conditions there was a lack or deficiency of some material or materails that went to build sound manhood and womanhood. The food they ate was the only means by which they could make good the daily loss and supply the various organs the materials they required. Deficiency of fresh air and food materials such as proteins, vitamins, mineral salts created deficiency diseases such as rickets, beri-beri, scurvy, etc., and many ill-defined conditions of ill-health and mal-nutrition, interruption of growth, irritability and nervousness of the child, affections of the eye, adenoids and enlarged glands. To prevent disease and restore sound nutrition and health to the child they must begin treating and feeding the expectant mother so that she might bring into the world a healthy child and be able to nurse it herself. A breast-fed child was stronger, healthier and less liable to disease than the one that was bottle-fed. They must reform the child's diet. How could the child grow strong and healthy on white rice, dal, pepper water and pickles? It must have chiefly milk and its products, whole-meal-bread, fresh butter, eggs, fresh green vegetables, uncooked food like salads and fruit and no tea or coffee or chocolates or condiments. It should be brought up in the open air, and be allowed to go almost naked as long as possible so that sunlight and fresh air, which are really food may kiss its body to vigour and health. Diseases like surgical tuberculosis got cured by exposure to sunlight. The school hours ought to be in the morning as heat enervated the body and the mental faculties. Rest of body and mind being essential to sound health the child should have eight to ten hours' sleep daily. As for sports and athletic exercises, they should not be overdone, lest they should injure the muscles and strain the internal organs, such as the heart, etc.

(*The Hindu*).

Advances in Obstetrics.

At a clinical meeting held on 29th February at 5-15 p. m. under the auspices of the Madras Branch of All-India Medical Licentiates' Association at the "Giffard School," Government Hospital for women and children, Egmore, a very large gathering of the members of the medical profession at Madras, including ladies and medical students was present.

Rao Bahadur Dr. A. Lakshmanaswami Mudaliar, B.A., M.D., F.C.O.F., read a paper on "The Recent Advances in Obstetrics" and explained the same through lantern pictures exhibited on the screen. Among other points of practical importance to the general medical practitioner were the anæmias, early diagnosis of pregnaney through the help of X-ray photographs, induction of labour, and the place of contraceptives in life. The learned doctor pointed out some of the latest obstetrical therapeutics including instrumental application gained by his vast experience in the line and from his recent continental tour.

At the end a business meeting was also held at which Dr. D. V. Venkappa, the Provincial Secretary of the Association, was unanimously elected to be one of the *ex-officio* members of the governing body of the Madras Branch. Among other resolutions placed before the meeting was the one regarding the T. A. Bill of the Madras delegate to Dharbhanga conference, which was passed unanimously. The meeting terminated with a vote of thanks to the chair and the authorities of the institution for having allowed the use of the school for the day's function.

ASSOCIATION NOTES.

The All-India Medical Licentiates' Association.

At a meeting of the Madras Branch of the above Association held at Ganamandir Thambu Chetty St., at 5-30 p.m., a larger gatheing of L. M. Ps. was present. Dr. U. Rama Rao was at home to the members. Major V. Mahadevan, I.M.S., who occupied the chair expressed gratification at the opportunity to meet the gathering and hoped that all the licentiates would muster strong under the banner of a common association, like the All-India Licentiates' Association. After the reading and confirming of the minutes of the previous meeting Dr. U. Rama Rao the President of the Association moved the following resolutions in connection with the All-India Medical Council Bill, all of which were passed unanimously. "The All-India Medical Licentiates Association, Madras Branch, having further considered the Draft Bill of the Government of India to establish a medical council for India resolves (*a*) That a new section No. 20 be inserted in the Bill defining specifically the privileges and rights which a Registered Medical practitioner would enjoy. (*b*) The medical qualifications granted by medical institutions outside British India which are included in the second schedule shall be recognized medical qualifications for persons enrolled or entitled to be enrolled in the provincial medical registers up to the date of the enactment of this Act. (*c*) In section 23 of the Government of India Bill, in line 4, after the words "Governor General in Council" add the following "Provided that no permanent appointments or commitment shall be made by the Governor General in Council."

Dr. G. Subbarayudu, the Madras Delegate to the Darbhanga Conference, then gave a detailed description of the Silver Jubilee celebrations and Exhibition and also, the important resolutions passed and the scientific papers read before the open conference. He also announced that the next All-India Medical Licentiates' Conference will be held at Madras and impressed on the necessity of making it successful and worthy of the Madras Presidency. The next item on the agenda was a lecture by Dr. P. Rama Rao on "Rontgenology in Vienna". Dealing with the important pathological conditions of the digestive tract, such as gastric and duodenal ulcers the Lecturer explained through the help of lantern slides, the structure of the mucous folds in the diseased and normal conditions. He gave his impressions on the recent and up-to-date advances made in Vienna in this branch of medical science. Major Mahadevan, I. M. S., in his concluding remarks expressed his satisfaction at being present at the function and felt that he was one of their own in the matter of their professional advancement, aspirations and recognition. He expected that the increased course of study of the L. M. Ps. will come into effect from next July and thus the differences in the profession will be

removed by raising the status of the L. M. Ps. to that of the graduates, so as to have a uniform standard of medical education and qualification all over India, He also expressed gratification at the interesting lecture given by Dr. P. Rama Rao.

Dr. D. V. Venkappa, the Provincial Secretary of the Association, in proposing a vote of thanks to the chair, the host and the lecturer of the evening, summarised the activities of the Branch Associations and expressed the need for many more.

Madura Medical Association.

FOURTH ANNIVERSARY CELEBRATION.

The fourth Anniversary of the above Association was celebrated on Thrusday, the 18th February 1932 at 5-30 p.m. at the Bungalow of Major M. M. Cruickshahk, I.M.S., the District Surgeon, and President of the Association. There was a large gathering of medical practitioners, more than 42 members being present on the occasion. Major and Mrs. Cruickshank were " At Home " to the members; at the delightful gardenparty, the members were treated to light refreshment and tea served on a lavish scale and the members spent nearly one hour in pleasant conversazione.

The actual meeting was held at the open space close to the main buildings, with Major M. M. Cruickshank, I. M.S., as President who wished all success to the Association in its activities and who appealed to the members who were in arrears of subscription, to pay up their arrears and help the cause of the Association in all possible ways. Dr. A. N. Menon, M B., B.S., the Honorary Secretary, presented the Annual Report which showed all round progress and good work of the Society during the year under review. The election of the office-bearers for the ensuing year was done at the meeting.

Major M. M. Cruickshank briefly explained the underlying principles and demonstrated the " Duochrome Test " for refraction to the audience. Dr. M. V. Natesan the Radiologist, gave an addrees on " Pitfalls in X-ray Diagnosis ", exhibiting a good number of radiographs on the screen. He pointed out that many of the pitfalls can be avoided by a greater co-operation of the general practitioner with the X-ray Specialist. He also laid emphasis on the fact that X-rays are after all only aids to the clinician and not intended to supplant him and that the final appellate authority is the Surgeon.

With the usual vote of thanks, the meeting terminated.

THE FOURTH ANNUAL REPORT.

I have the honour to present to you this evening the Fourth Annual Report of our Association. The Association has put in another year of solid good work. For the last annual meeting, in the absence of our permanent President, we were fortunate to secure the services of Major-General C. A. Sprawson, C. I. E., I.M.S., the Surgeon-General with the Government of Madras, to preside over the function. He was quite well pleased with the activities of our Association and his actual participation in the proceedings of the meeting has given us a good deal of encouragement. He pointed out the importance of an association like ours in the medical life of Madura and advised all medical men and women to join its folds.

Members.—Inspite of a few members resigning their membership on account of their transfer from the station, and in spite of a few members' resigning without giving any reason at all, the total number continues to be the same. The present number of members on the rolls including three non-residential members is 47.

A few changes occurred in the Governing Body during the course of the year. Major M. M. Cruickshank, I.M.S., was unanimously elected as our President, when Dr. B. Iswarayah left Madura on transfer. Dr. Miss I. M. Roberts, an active member left Madura on furlough and Dr. Miss A. M. Otto has filled up the vacancy. Dr. C. S. S. Sarma and Dr. K. V. Gopalakrishna Iyer had to leave us almost at the same time and Dr. E. W. Wilder and Dr. K. R. Subramania Iyer succeeded them in the Governing Body. Lastly Dr. M. V. Natesan was elected for the vacancy caused by the sad demise of Dr. P. Appavoo Pillay.

In this connection, I regret very much to record the recent deaths of Dr. B. Iswarayah, a former President of our Society and of Dr. P. Appavoo Pillay, an active member of the Governing Body. I also place on record the Association's high appreciation of their valuable services.

Dr. T. S. Venkataraman has been elected as one of the auditors in the place of the late Dr. P. Appavoo Pillay.

Meetings.—There were on the whole 9 General Body Meetings and 7 Governing Body meetings during the year. Only one Governing Body Meeting had to be adjourned for want of *quorum.* Although the clinical meeting were not as many as in the previous year, two special meetings were held, when important resolutions were discussed and passed.

During the Epidemic of Cholera last year, in the town of Madura, the Association volunteered its co-operation and helped the Municipal Health Staff by deputing a dozen Honorary workers for doing inoculation work and other preventive measures. The Association also helped the cause of the Licentiates by convening a special meeting when an important resolution requesting the Government to include the Licentiates in the proposed All-India Medical Council Bill was unanimously passed.

Under the auspices of the Association, there was also a cinema show arranged by Messrs. Havero Trading Co., who put on the screen their highly instructive film on "Neosalvarsan, its manufacture and standardisation".

The attendance in all these meetings was quite satisfactory. and the list of subjects discussed and the case reports presented is given in appendix B.

This year the Association successfully organised three Social gatherings; first to meet Major-General C. A. Sprawson, C. I. E., I. M. S., the Surgeon General, second to bid farewell to Dr. Miss I. M. Roberts and the third to meet Rao Bahadur Dr. A. Lakshmanasami Mudaliar, the President of the Madras Provincial Medical Association.

During the year the Association had to leave the rented rooms in the Y.M.C.A. Buildings and the properties of the Association, the almirah and the journals are temporarily kept in one of the rooms at the office of the Secretary. Last year we held most of our meetings in the Government Head Quarter Hospital and also, on kind invitation, at the bungalows of Dr. E. W. Wilder and Dr. Miss A. M. Otto. Dr. E. W. Wilder and Dr. Miss A. M. Otto were also "At Home" to the members at the respective meetings. I take this opportunity to express our thanks to the three Superintendents of the three hospitals in the city for allowing us the free use of the hospital premises for holding our Association meetings.

Journals.—Last year, the Association has subscribed for a new journal "The Antiseptic" in addition to the journals already in the list. A few other journals were also made available to the members by the kind courtesy of Dr. Miss A. M. Otto and the South Indian Medical Union.

Finance.—The financial statement for the year ending December 1931 is given in Appendix C. One of the members has given a donation of Rs. 100 to the Association in October last with the request that he may be enlisted as a Life-member of the Association. We have been able to save more than Rs. 1,200, during the course of the last four years, by carefully economising expenditure, but this amount does not suffice to enable the Association to have a permanent building of its own, where the Association can house its Library and Reading Room. Hence I earnestly appeal to all the members, especially to those members who are in arrears of subscription to pay up the arrears and help the cause of the Association in all possible ways, so that we may attain our object at an early date.

Before I conclude, I wish to express my heartfelt thanks to our kind and sympathetic president Major M. M. Cruickshank, I. M. S., who has evinced a keen interest in the activities of our Association ever since he accepted the office of the President.

A. NARAYANA MENON, M.B., B.S.,
Hony. Secretary.

FINANCIAL STATEMENT FOR THE YEAR.

31st December 1931.

Receipts.	Rs.	A.	P.	Expenditure.	Rs.	A.	P.
1. Balance on 1—1—31.	900	15	4	1. Pay of Peon ...	115	0	0
2. Subscriptions from Members ...	474	0	0	2. Reading Room rent for four months ...	42	0	0
3. Donation from Dr. A. Narayana Menon for a life membership ...	100	0	0	3. Subscriptions for Journals & medical annual ...	102	15	6
4. Balance of subscription collected for entertainments of Lt. Col. Gray & Major General Sprawson ...	25	2	9	4. Stationery and Stamps and printing charges ...	9	6	3
5. Interest on Savings Bank a/c for 2nd half of 1930 ...	16	1	10	5. Entertainments and Socials ...	29	2	0
6. Interest on Savings Bank a/c for 1st half of 1931 ...	21		10	6. Cash on Hand ...	61	4	4
7. Interest on Savings Bank a/c for 2nd half of 1931 ...	24	0	6	7. Cash in Bank ...	1,200	11	2
Total ...	1,561	7	3	Total ...	1,561	7	3

Audited and certified correct by
(1) DR. T. S. VENKATARAMAN.
(2) „ P. N. RAMASUBRAMANIAM.

R. DEVADOSS PILLAI,
Hony. Treasurer.

The Madras Medical Co-operative Society, Ltd.

This is a Society which has been started and registered under the Co-operative Credit Societies' Act (Act II of 1912) with an authorised capital of one lakh of rupees made up of 10,000 shares of Rs. 10 each.

The liability of the members is limited to the amount subscribed. The members are all medical men and its operation is confined to the Presidency of Madras. The objects of the Society are :—(1) the encouragement of thrift and self-help; (2) the purchase of medical and surgical requirements for the retailing to the members of the Society, the carrying on in common for the benefit of the members of the Society of the trade of general dealers and the establishment and the conduct on co-operative principles of such other lines of work or departments of business as may from time to time be resolved upon by the general body of members; (3) the dissemination of the knowledge of co-operative principles and their realisation as far as practicable; and (4) the doing of all such other things as are incidental or conducive to the attainment of the above objects.

The management of the Society rests with the Board of Directors consisting of seven members. The present Board consists of

President.—Dr. M. Subramania Iyer, B.A., M.B & C.M.; *Directors.*—Dr. M. Sanjeeva Rao, M.B., B.S., Dr. M. Devaji Rao, Dr. U. D. Gopal Rao, Dr. Perceival St. Clair Mitchell, I.M.D., and Dr S. Anthonisamy Pillai *Managing Director.*—Dr. K. P. Rama Hebbar, L.M.F.

The Registered offices are 246, Thambu Chetty Street, Georgetown, Madras.

The Government are pleased to make the following appointments of Honorary Medical Officers to the Government Royapettah Hospital, Madras :—

Mr. H. Chatterjee, L.M.S., Honorary Physician.

Mr. B. N. Sundaravadanan, B.A., M.B.B.S., L.R.C.P. (Lon.), F.R.C.S. (Eng.), Honorary Surgeon.

Mr. K. M. Sambandan, L.M.S., L.R.C.P. and S. (Edin.), Honorary Assistant Surgeon.

Mr. K. S. Vedachalam, B. Sc. M.B. (Cal.), Honorary Assistant Physician.

Miss A. Mamman, M.B.B.S., Lady Assistant Surgeon.

Educating the Public.

Germs have fleas. The fleas bite the germs. This makes the germs mad, and more dangerous to human-kind, or drugs the germs into harmlessness. Dr. F. D'Herelle of the Yale School of Medicine recited this fact to the scientists attending the 33rd annual meeting of the Society of American Bacteriologists to-day. The germ fleas, Dr. D'Herelle said, are called "Phages". Laboratory researchers are now breeding "phages" to learn what makes them bite, and their other characteristics.

Boston record—Baltimore,

December 28, 1931.

BULLETIN
OF THE
SOUTH INDIAN MEDICAL ASSOCIATION.

MARCH, 1932.

The Medical Budget, 1932-1933.

Shrinking revenues do not provide the exact back-ground for flighty budgets. There is, therefore, in the Madras medical budget no striking departure from the prosaic provision of funds just sufficient to carry on medical relief and medical education to the limits of previous commitments. There is throughout a general reduction in the amounts allotted to each item. Though the reduction is only a few thousands of rupees in each, yet the provision made is less by 8 lakhs as compared with the previous year's budget or 4·5 lakhs less than the revised estimate of 1931-32. It might be regretted that such essential activities as provision for medical relief and education should be so badly restricted. But incurable optimists that we are, we consider that the blighted revenues are a blessing to the medical department. In the past few years when revenue was plentiful and the medical department was allowed quite a fair share of the windfall, there was phenomenal activity in the department. But this activity was mainly evident in two directions, one the construction of imposing buildings in the place of old ones, and the other, the creation of a number of highly paid appointments or the multiplication of old appointments, together with sanction of generous allowances under various names. In fact new appointments came in such profusion and allowances were sanctioned with such ease, and almost new recruits to the service were elevated to higher grades so rapidly that people began to wonder whether those many appointments were not created just to provide convenient, comfortable and lucrative berths to one or other of the favourites of the powers that controlled the department. Whether that opinion was mistaken or not, the present budget proposals do not forecast a " favourites ", year, to use a racing term.

There is a slight increase in the grants to local bodies towards medical relief and building grants. But considering the extensive areas and the large number of institutions, we would have appreciated a somewhat generous increase in these. The pay of officers in colleges and schools cost the tax-payer about three-fourths of a lakh less than in the previous year and the value of purchases of stores in England is cut by about 50 per cent

There are a few items in the budget proposals that might be usefully reconsidered by the Government. There are a fair number of civil surgeons who are classified as selection grade officers. We do not know what tests these officers satisfy before they are brought into this list. To some they appear as a motley crowd that has some how strayed into this ring. With rumours of retrenchment thick in the air, we expected to find " special pay " much less in evidence. We are disappointed. Even so it is difficult to understand why some should get Rs. 200 and other less.

Tuberculosis Institute.—Coming to individual appointments, the Director of the Tuberculosis hospital and institute is graded for Rs. 600—1,200. Since the officer is allowed private practice, the pay is unnecessarily high. This appointment is an ideal one for replacement by honorary staff. The administration could be carried on by a paid lay official and the clinical and investigation work satisfactorily carried on by Honorary medical staff. We have reasons to believe that the first Director actually submitted somewhat

similar proposals to the Government about seven or eight years ago.

Professor of Bacteriology.—Under Medical Colleges provision is made for one Professor of Bacteriology on the pay of Rs. 625—1,150. There are two Medical Colleges, but only one appointment is specifically mentioned on this high pay. We wonder what scale of pay is attached to the other professorship. We believe, subject to correction, that these professors are not stopped from engaging in remunerative private practice. It is incomprehensible therefore why one of the two, who teach the same subject, should have a higher pay ; not only that, but a pay higher than that of most of the other professors of the same college. The newly appointed Director of Pathology of the Madras Medical College is reputed to be a highly capable Bacteriologist with a record, to his credit, of recognised original research in Bacteriology. As such he should still be keen on continuing further work in this field. Could not the Government avail themselves of his help and entrust the teaching of this subject to his care with the help of a capable assistant on a much lower pay than that fixed for the present professor of bacteriology?

In most institutions in other countries, bacteriology is a part of the pathological department. It is rarely that a separate chair is established for the subject of bacteriology, and then it is generally as a mark of honour to the person of a very great bacteriologist. If the Government is agreeable to our suggestion, it would save some money and also fall into line with what obtains elsewhere.

Lady Tutor.—A woman assistant surgeon on a pay of Rs. 200—450, as a tutor to the women students of the medical college is rather a curious item. There is no such tutorial appointment for the boys. Is it that the women students are so backward that they need a special tutor or is there such a versatile medical woman who can tutor the woman students in all subjects and methods and whose services the Government are anxious to utilise for the immense benefit of the frail students of the college?

The Honorary system : Its advantages.

The advantages of the system of staffing the State hospitals with Honorary officers have to be considered from more aspects than one. For the sake of convenience they may be grouped as follows :—

1. The advantages to the State.
2. The advantages to the sick public.
3. The advantages to the profession itself.

The advantages to the State are many. The first thing that will strike any one is the financial aspect. It is obvious that an unpaid agency is certainly much cheaper than a paid one. But cheapness may be obtained at a very dear price, *viz.*, the price of efficiency. If it is guaranteed that with the honorary system, efficiency can and will also be maintained than the financial gain should be welcomed in any State. Now there are two ways by which one can assess the efficiency of the honorary system, one, to know the number of countries where the system is working, and how it is working there ; the other to study their relative merits in places where both systems are functioning.

THE NUMBER OF COUNTRIES.

The Honorary system has been long in vogue in the United Kingdom, in France, in America and in Germany (with certain modifications). Let us consider how far the system has been successful in each of the countries.

England, etc.—The Honorary system with voluntary hospitals is still in

vogue. It has been attempted to be modified in certain directions in some places with no great success. Before proceeding further, attention should be drawn to the controversy that is going on in England as to the correct management of hospitals. The question that is being discussed is, whether the voluntary hospital system, *i.e.*, hospitals raised and managed by private agencies, absolutely independent of the State, or the State hospitals system, *i.e.*, hospitals raised and managed by the State should be the policy of the future. Those that advocate State management and condemn the voluntary hospital system do so because they believe that it is not possible to get sufficient funds by contributions from the public to build and run a modern hospital. Owing to the financial stress on account of a falling off in the contributions to the hospital after the war, this view has been held by some. This controversy did not arise from any question of inefficiency of the Honorary medical staff of the voluntary hospitals. Even the advocates of the State hospital management agree that a great part of the staff should continue to be Honorary or part timers. This controversy has been taken advantage of by some people in Madras to make misleading statements, such as, that the voluntary hospitals are being given up and that the Honorary system is condemned in England. Neither of the above statements is correct, and no voluntary hospital has yet been changed into a State hospital; nor, is there any near chance of the Honorary staff being replaced by full time salaried men. What has really happened in England is that in addition to, but not in place of, the Honorary staff, a small number of full time appointments have been made in some Universities and medical schools.

France.—To this day, all hospitals are staffed with Honorary men. Those of them who have anything to do with teaching in medical schools are paid only for the teaching, hospital work being entirely unpaid for.

This two great countries have been working the Honorary system for a long time, and as they continue the same, one is warranted in the belief that the system is efficient.

Countries where the two systems are working.

Bombay.—Those who are acquainted with the working of the large teaching hospitals and medical colleges in Bombay hold very strong opinions about the efficiency of the Honorary system. One medical college teaching up to the University standard is being run entirely with an Honorary staff.

This is enough to show that the Honorary medical staff of hospitals is no less efficient than the paid staff.

Obvious and marked as the financial advantage is, it is not the most important consideration in assessing the advantages of the Honorary system.

The Government in the department of Public Health is responsible to the public for the provision of a sufficient number of doctors to cater to the needs of the sick. This is its primary concern. It is responsible to see that the doctors it provides are fully efficient—as efficient as the modern progress in medicine can equip them to be, as efficient as the general practitioners in other countries are. It is responsible to provide all the available facilities necessary to efficiently equip the medical men. It is responsible to provide medical schools of an order not inferior to those in other countries.

For the satisfactory discharge of the above responsibilities three things are required—money, men and method. If a large proportion of the money avail-

able is spent on a salaried service, the money that is required for better equipment and organisation is stinted. The richest countries in the world, *e.g.*, U. S. A. find it too difficult to satisfactorily finance a large number of salaried appointments. Only a few of the appointments in a small number of first class teaching hospitals are held by full time paid men. If, therefore, a State which professes chronic poverty starts with the idea of staffing all its hospitals and medical schools with relatively highly paid men, it cannot proceed far to satisfy the medical requirements of the country.

Other countries are enabled to provide a large number of well equipped medical men and to run great teaching institutions with a large staff not by their financial profuseness, but by their superior organization of a happy blend of a few high-paid full-time men, with a large number of small-paid full-time, and part-time assistants and a host of Honorary workers. This is what obtains today in America, Canada, England and Scotland and Germany.

It is in the proper equipment and management of teaching institutions that the Honorary staff can play and should be allowed to play a very important part.

The object of a teaching hospital is manifold. The current local idea seems to be that teaching hospitals are so called because they teach undergraduate medical students in the hospitals attached to the colleges and the medical pupils in other teaching hospitals. In America, Germany, France and also in England these hospitals are considered to be training places, as much for the fully-qualified and the long-qualified practitioners as for undergraduates. Post-graduate teaching and learning are considered to be of equal importance, This post-graduate education is still in its infancy in England, but on the continent, especially in Vienna and Berlin, great attention is paid to this side of medical education.

When this use of the hospitals is recognized, the next question that has to be solved is, how we are going to manage this teaching and training of graduates. Here again, the local idea appears to be that there is no better way of doing it than by selecting a fraction of newly qualified graduates to work as house-surgeons and house-physicians for a year or a little more and then to select from among them a smaller fraction to be entertained into a salaried service as assistant surgeons —there is no such thing as assistant physician, or assistant gynaecologist in Madras.

Granting that starting as an assistant surgeon is the best means of post-graduate learning—what is to happen to the larger number of people left out? If it is maintained that a year's training as a house-man is sufficient to start practising on his own account, is there no necessity for a periodical "brain dusting".

On the other hand what obtains in other countries?

In all big teaching hospitals there are a large number of chief men each with more than one assistant, all Honorary, to do the teaching in the school and in the hospital. They are only paid for the teaching in the school. With the assistants there are a large number of house-men with a small allowance per annum. The chief and the assistants practise outside. The experience gained in teaching students and working in the hospitals is made available to the public outside. During the period of assistantship they specialise in one or more things. Those of them who have special aptitude for teaching remain attached

to teaching institutions; others may select to transfer their honorary service to non-teaching hospitals and practise outside. This system is very marked in America where about 60 per cent of doctors are attached to hospitals in one professional capacity or other.

The idea underlying this latter system is not teaching or learning, but teaching and learning; for it is well known that there is no better method of learning a subject than by teaching it. This undoubtedly helps to make learned teachers and practitioners and consequently highly efficient doctors.

In none of the countries above mentioned is there a " medical service ". In no country or University has a man become a Professor merely by the fact of increasing years or by the virtue of possessing University degrees alone. In no country is found the spectacle of a young Medico pitchforked into a senior hospital appointment or University professorship, the day after he manages to get an M.D. degree or M.S. or M.R.C.P. of Ireland or Edinburgh. The prevalent idea in Madras of selecting junior men from the ranks and posting them as assistants to the various professors with the object that they may be ready to occupy the chair in the fullness of time is simply laughable.

Men are appointed to chairs not because of their being assistants to the retiring professors but because they have done work of abiding merit. It is quite common to appoint men from outside absolutely ignoring the long time assistant. For example the present University Professor of Physiology in London and the Professor of Anatomy in Edinburgh are rank outsiders. The appointment of Osler from America to the regius Professorship of Oxford, ignoring all the famous men in England and Scotland was of this nature. The present Professor of Anatomy in South Africa was a junior assistant in Edinburgh before he was appointed to the present place. By restricting the choice to men from a limited cadre and appointing the assistant to succeed to the chair, the field of choice is woefully circumscribed.

It is here more than elsewhere that the advantage of the Honorary system is most marked. The services can have only a limited number of men taking the finance into consideration. Certainly a very much larger number of men can be entertained in a system of the Honorary workers. Where only one paid assistant can be engaged, many Honoraries can be appointed, and in a short time, a larger number of well trained men will be available. As considerations like exigencies of service, seniority and claims for larger pay, etc., do not arise, the freedom of choice of men is happy and unlimited. If for this and no other reason the Honorary system is greatly desirable.

The question that would certainly be asked by people who are not familiar with the conditions in other countries is " How would these men who are willing to give their services free, live ? The answer is, by teaching, coaching students for examinations, demonstratorship, examinership, doing special laboratory work, assisting seniors in their practice in specialised jobs, etc. This gives them a little money to live on, gives them opportunities to equip themselves and affords facilities to test capacity. It also conduces to healthy rivalry and a desirable spirit of emulation.

Some people maintain that the Honorary system is being given up in some of the countries, especially for teaching appointments. As a statement of fact it is not accurate. But even if it is true, conditions obtaining in this country more particularly in this Presidency, have to be taken into consideration in devising any method of medical relief

and medical education. It is undeniable that the finances are not sufficient to extend medical relief as one would desire. It is also a known fact that the methods of education in this country are far behind those obtaining in other countries which work a different system. Therefore one has to take into consideration the cheapest method of obtaining medical relief and imparting education without impairing efficiency. This system is being tried in a limited way in Bombay and to some extent in Calcutta and it has been found to yield excellent results. And there is no reason why one should anticipate any different result in this Presidency. This would be the only solution to effect a change in the present unsatisfactory standard of medical education which is being imparted in a number of medical schools in this Presidency. With an increasing association of Honorary medical men in the schools and in the hospitals, a great amount of money would be released and would be made available to be spent on up-to-date equipments which are very essential if the laboratories attached to these institutions are to compare favourably with those in other countries. There will also be found a much larger number of teachers and tutors and demonstrators to help the students in their work in the schools.

Recommendations of the Central Council of the Indian Medical Association on the proposed Indian Medical Council.

From

The Joint Hon. Secretaries,
Indian Medical Association,
67, Dharamtala Street,
Calcutta.

To

A. B. Reid, Esq., I.C.S.,
Offg. Secretary to the Government of India,
Education, Health & Lands Department,
Simla.

Dear Sir,

We are directed to address you in reference to your circular letter No. 1494-H, dated the 31st August 1931, regarding the establishment of an Indian Medical Council, and to place before you for the consideration of the Government of India the considered views of the Indian Medical Association on the subject of the Bill.

2. Before proceeding to record the views of the Association, we may be permitted to remark that in a measure of such importance much greater opportunity than has been allowed should have been given to public bodies for consideration of the Bill.

3. It would perhaps be helpful to state that the Indian Medical Association is the organisation which was formerly known as the All-India Medical Association. It has branches throughout India and with it is affiliated a number of similar institutions in the different provinces. Its membership includes University Graduates as well as Licentiates and on its roll are members of the independent medical profession as well as medical officers serving under Government or Local Boards. The expression of opinion on the Indian Medical Council Bill expressed in the following paragraphs thus represents the considered opinion of the medical profession throughout the country, and would, therefore, we trust, receive the weight before Government formulate their final proposals for submission to the Legislative Assembly.

4. In regard to paragraph 2 of the letter above mentioned, the Association considers it unfortunate that at the Simla Conference of June 1930 no opportunity was given to the independent section of the medical profession in India as such, (who stand to be most affected by the provisions of the Bill under contemplation, and who in fact form the vast bulk of the medical profession in this country) to send a direct representation to the Conference and to place before it the views of this large section. As the main object of establishing an Indian Medical Council is, as was resolved at the Simla Conference, "to put our own house in order and to establish a minimum uniform standard of qualifications for India and to promote co-operation among the Universities," the constitution of the Council must be primarily orientated to this purpose. The report of the discussion at the Conference shows that the members desired an *independent* and self-contained Council with a large preponderance of persons who have an academic outlook and are connected with teaching. It is surprising to note that the report gives no reason why the members considered that in an independent Council of 28 members there should be 12 persons directly representing the Government. It is equally strange why it was considered essential to let each provincial Government (even the Government of Central Provinces, which have no direct interest in imparting instruction to medical graduates) have a direct representation on the Council. The Association is emphatically of opinion *that the Provincial Governments need have no direct representative on the Council.*

5. The essential purpose of such a Council, in the opinion of this Association, should be :—

(1) To control the standard of medical education and professional qualifications, with a view to assuring that the medical practitioners possess the necessary knowledge and skill for their professional work ; and

(2) To assure the maintenance by registered medical practitioners of the high standard of professional conduct and rectitude.

The active co-operation of such a Council may also be secured in the recruitment for public medical services by means of open competitive examinations, as also in regard to the conduct of medical research, in the compilation of a Pharmacopœia and other functions for the general benefit of the profession as well as of the country. These features should be clearly indicated in the Objects and Reasons of the Bill.

COMPOSITION OF THE INDIAN MEDICAL COUNCIL.

(*a*) *President.*

6. The only reason adduced as to why the President should be nominated by the Governor-General-in-Council is that "of the close association which should exist between the Council and the Central Government." In the opinion of the Association, the Council if it is to function as an independent body should elect its own President. In view of the fact that the proceedings of the Council will be subject to confirmation by the Governor-General-in-Council the President who is the chief spokesman of the Council, should not be a person nominated by the Governor-General-in-Council. It may be mentioned that the first Medical Council formed in England in 1858 had the right to elect its President ; the Privy Council of which the Medical Council was an agent by statue, did not claim the right to nominate the President. There appears to be no valid reason why the Governor-General-in Council should be given this power of nomina-

tion. Accordingly, this Association is opposed to granting power of nomination of the President of the Council to the Governor-General-in-Council either perpetually or at the inception of the All India Medical Council.

(*b*) *One member to be nominated by each Local Government.*

7. In the view of this Association, the interests of the Local Government or of the Indian Medical Council would not be best served by this method. They would, however, provide for connection between the Council and the Provincial interests by the election of a representative to the Council from the Provincial Committees to be constituted in the manner recommended in paragraph 13 below.

(*c*) *One member elected by the Medical Faculty of each University in India.*

8. In paragraph 5, the issue is raised *whether each University in a province with a medical faculty, should have separate representation on the Council or whether the Unversities in a Province should be grouped together for the purpose of electing one representative between them.*

While this Association agrees that the Council should not be rendered unwieldy, it considers it essential that the Universities having medical faculties should be separately represented. It will be realised that such institutions are primarly responsible for the esta :—blishment and maintenance of standards of medical education in the different parts of India and for this important reason each such University should be allowed representation. In view of the fact, however, that certain medical faculties are too small to act as a suitable electorate the Association propose that the election of the representative of the University, should lie with the Senate. This method has the additional advantage in that the responsibility for election is placed on the real body entrusted in each University with the control of higher education and the conduct of examinations.

(*d*) *One member to be elected by the medical graduates of each province in which there is a medical register.*

9. On the question whether graduates should have any direct representation or whether Provincial Medical Councils should elect one person on the Council (Paragraph 6) it will be realised that one of the functions of the Council will be to enter in the Register or to erase from it, for professional misconduct, the names of graduates. Therefore it is reasonable that the graduates should have someone to represent their interests. From this point of view the British Medical Act of 1886 gave representation to registered practitioners. The same argument applies with equal cogency to the Indian Medical Council.

10. With regard to the qualifications of graduates prescribed under clause 5 (3) of the Bill, it is felt that restriction to those with teaching experience of at least 5 years in a medical college affiliated to a British Indian University would, in effect and for many years to come, invariably amount to the seat going to an official member from the graduate constituency as, except in the case of only two institutions in the country, all the others are staffed by Government servants, who only would possess the requisite qualification. If the graduates are to be truly represented, the qualifying clause, *viz.*, Section 5, subsection (3) requires to be deleted.

INCLUSION OF LICENTIATES.

11. As the Association is of opinion that the Licentiate Group forms the largest section of the medical practi-

tioners in India and on them devolves the major portion of work of rendering medical aid to the masses, no Indian Medical Council would be adequately constituted if this very large element is left unrepresented on it. It was a somewhat similar consideration that led to the inclusion of representatives of the dental profession in the British Medical Council. If the primary and main object of the Council is to establish uniformity of minimum standards in India and not merely to seek recognition of Indian Medical degree by the General Medical Council of Great Britain then it becomes increasingly evident that the Licentiates require to be brought within the purview of the Bill and given adequate representation. The inclusion of the Licentiates in the Indian Medical Council will help in raising the standard of their education, by insisting on the improvement of the curriculum and equipment of their schools and particularly in strengthening the quality of their teaching staff. The Association recommends that the Licentiate Group in each province should be allowed one representative each in the Council.

Reciprocity.

12. On the question of reciprocity, this Association is emphatically of opinion that the Council should be free to accept the medical degrees of those countries only which accord the same privileges of recognition to the medical degrees of Indian univesities and whose standards of medical education and examination are in no way less than those that may from time to time be prescribed by the Indian Medical Council when established It is nct in keeping with this intention, therefore, that British degrees should be automatically recognised by inclusion in the First Schedule of the Bill. This question is essentially a matter for reference to the Council after its formation.

13. With reference to paragraph 8 of the Government of India's letter under reply, the Association is in general agreement with the view expressed therein. They would, however, remark that the Provincial Medical Councils are also important provincial bodies concerned with the maintenance of standards of medical qualifications; it is also noted that your Government consider it desirable, as suggested in paragraph 6 of your letter "that the link between the provincial bodies and the Council should be close." In order, therefore, to ensure this the Association propose that the Provincial Committee proposed in Section 11 (1) should be composed as follows:

(*a*) The members of the provincial medical Council.

(*b*) Representative of the university in that province elected to the Council.

(*c*) (*i*) Representative of the graduates of Indian universities.

(*ii*) Representative of the licentiates in the province elected to the Council.

(*d*) The member nominated to the Council by the Governor-General-in-Council from the province, if any.

Fees.

14. With regard to the question of fees, our Association favours the view that fees might be charged provided that the figure is not prohibitive. It will be realised that the inclusion of Licentiates would provide a large sum towards the maintenance of the Council. This would permit of a substantial reduction in fees from the figure of Rs. 75, which has been suggested. A fee of about Rs. 25 should suffice.

Privileges.

15. It is necessary at this juncture to draw attention to a serious omission in the Bill. Apart from the question of benefit in status in registration it is essential that certain definite privileges ought to be allowed to those who register, and thus subject themselves to a discipline. It will be noted as against the responsibilities laid on the medical practitioners in all countries, where Medical Acts of more or less a similar nature are in force, that they are allowed certain rights and privileges. For example, no medical practitioner can be appointed in the Military or Naval or Air Force Medical Services of the country or to any civil medical post under Government whether central or local or under any local authority, or to any hospital or dispensary, or on ship registered in the country or plying in territorial waters, unless he is a registered medical practitioner, that is, unless his name appears on the Medical Register of the country. Likewise, no medical certificate is legally valid unless it is signed by a registered medical practitioner, nor will his evidence in giving medical opinion be accepted in a Court of Law. Dangerous drugs or poisons are also not allowed to be administered by a practitioner unless he is registered. A medical practitioner would also not be entitled to administer anaesthetics, or recover any charge in any Court of Law for any medical or surgical advice, attendance or for the performance of any operation, or for any medicine which may have been prescribed and supplied, unless he is registered under the Medical Acts of the country, nor would any person be protected in charges of manslaughter, in the case of persons dying under their treatment, unless registered.

16. It will thus be seen that the Medical Acts in all countries supervise the medical education and qualifications and lay onerous responsibilities on the medical profession in respect of professional conduct of a high order. In return for such demands, the medical practitioners are protected and privileged in various ways indicated above. Unless such protection was afforded, it would hardly be worth while being on the Medical Register. In the Indian Medical Council Bill as circulated, there is, however, an entire absence of any reference to the privileges or immunities or protection of the kind described above which medical practitioners are assured under similar Acts in other countries. The omission cannot be a mere oversight, as reference to these privileges was included in the corresponding Bill circulated by the Government of India in 1928. Another striking omission in the Bill, as it stands at present, makes it possible for any foreign national to settle in India and to do what he likes in the country in the say of professional practice without any restriction and without having to observe any discipline under the Indian Medical Council. He may even obtain service under the Indian Government, without being registered in the country, if the medical advisers of the Government were inclined or induced to push his claims. The omission in the Bill will also need to be rectified. We would, therefore, suggest that the Bill be so amended that unless a medical practitioner has his name entered in the Indian Medical Register, he will not be allowed the privileges already referred to above and others of similar nature. The effect of this amendment would not be to exclude any non Indian simply because he is a non-Indian to practise or serve in India. It simply requires every medical man in India, whether Indian or non-Indian, desiring these privileges, to conform to the discipline and regulations of the Indian Medical Council.

17. With these preliminary remarks we would now refer you to the annexed statement in which the Association proceed to record their opinion on the various clauses of the Bill and to offer suggestions as to the manner in which the Bill should be altered.

In conclusion, we may hope that the Government of India will give due regard to the recommendations of this Association, which as indicated before represent the views of the independent medical profession in India, the largest element in this country, whose interests are so closely involved in the measures proposed.

We have etc.,

D. D. SATHAYE,
A. N. GHOSH,
K. S. RAY,
Joint Hon. Secretaries.

AMENDMENTS, ADDITIONS AND ALTERATIONS PROPOSED BY THE INDIAN MEDICAL ASSOCIATION.

The word "British" to be deleted wherever it occurs in the Bill.

PREAMBLE.

Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners and so to provide for the maintenance of a Register of qualified practitioners of modern scientific medicine in order to establish a uniform minimum standard of qualifications in medicine for all provinces such that persons attaining thereto shall be acceptable as medical practitioners throughout India; it is hereby enacted as follows:

SHORT TITLE, EXTENT AND COMMENCEMENT.

Section 1. No alteration.

DEFINITIONS.

Section 2. No alteration.

CONSTITUTION AND COMPOSITION OF THE COUNCIL.

Section 3 and the following section should read as follows:

Section 3. (1) After the passing of the Act the Medical Council in India shall consist of the following members, *viz*:

(*a*) Three persons to be nominated by the Governor General-in-Council;

(*b*) One person to be elected by the Provincial Committee from amongst members who have been elected to this body;

(*c*) One person to be elected by the members of Senate or University Court of an Indian University with a Medical Faculty;

(*d*) One person to be elected by the medical practitioners resident in a province in India and registered in a Provincial Medical Register and who possesses any qualification, granted or recognised by an Indian University or who possess any recognised medical qualifications under amendment of Section 18 of this Act;

(*e*) One representative of Licentiates registered in each provincial Medical Register.

(2) No act done by the Council shall be questioned on the ground merely of the existence of any vacancy in or any defect in the constitution of the Council.

(3) The President of the Council shall be elected by the members of the Council from amongst themselves.

MODE OF ELECTION.

Section 4. (1) An election under clauses (*b*), (*d*) and (*e*) of sub-section (1)

of Section 3 shall be conducted by the Provincial Medical Council concerned and an election under clause (*e*) of sub-section (1) of Section 3 by the senate or university court of the Indian University concerned in such a manner as may be laid down by regulations prescribed for the purpose by the Council under Section 24 provided that the first election under the Act, will be held in accordance with instructions to be issued by the Governor-General-in-Council on this behalf.

(2) When any dispute arises regarding any election to the Council, it shall in the first instance be referred to a Court of Competent Civil Jurisdiction in the area, and an appeal shall lie to the Governor-General-in-Council whose decision shall be final.

RESTRICTION OF NOMINATIONS AND ELECTIONS.

Section 5. (1) Save as regards the Council as first constituted under the Act no person shall be eligible for election under clauses (*b*), (*c*), (*d*) and (*e*) of sub-section (1) of Section 3 unless he is enrolled on the Register or on the Provincial Medical Registers.

(2) and (3) of Section 5 to be omitted.

(4) is to be numbered sub-section (2) and will read as follows :—

" No persons may at the same time serve as a member in more than one capacity."

INCORPORATION OF THE COUNCIL.

Section 6. The Council so consituted shall be body corporate by the name of the Council of Medical Education and Registration for British India, having perpetual succession and a common seal, with power to acquire and hold property both moveable and immoveable, and to contract, and shall by the said name sue and be sued.

TERM OF OFFICE.

Section 7. (1) Every member including the President, shall hold office for the term of five years from the date of his nomination or election as members. In the case of a vacancy arising in the Council, such vacancy shall be filled by the election or nomination as the case may be within 30 days of such vacancy occurring. A member or President so filling up a vacancy shall hold office up to the end of the term of the original member.

(2) No alteration.

Additions.

(3) Any member may at any time resign his appointment by letter addressed to the President of the Council.

(4) Upon the death or resignation of any member of the Council, some other person shall be appointed a member of the Council in his place by nomination or election, as the case may be, in accordance with the provisions of Section 3, and such person shall hold office for the remainder of the period for which the member in whose place he is appointed was nominated or elected.

(5) (*a*) Leave of absence from India may be granted by the Council to any member thereof for a period not exceediug six months.

(*b*) If any member of the Council leaves India without the leave of the Council, or does not return to India within the period of the leave granted by the Council, the Council may forthwith declare his seat vacant and such declaration shall have the same effect as resignation of his seat by the member concerned.

(*c*) In any case not provided for in clauses (*a*) and (*b*), if any member of the Council shall absent himself

from three consecutive meetings of the Council, the Council may forthwith declare his seat vacant and such declaration shall have the same effect as resignation of his seat by the member concerned.

MEETINGS OF THE COUNCIL.

Section 8. (1) The Council shall hold its first meeting at such time and place as may be apppointed by the Governor General in Council and thereafter the Council shall meet at least once in each year and as often at such time and place and in such manner as may be provided for in the regulation framed for the purpose by the Council.

(2) No alteration.

OFFICERS, COMMITTEES AND SERVANTS OF THE COUNCIL.

Section 9.

(*a*) Add " A President and " before the word " Vice-President," and at end, " but shall not be appointed as a Medical Inspector."

(*b*) No change.

(*c*) Add at the end " but shall not be appointed as a Medical Inspector or Visitor."

THE EXECUTIVE COMMITTEE.

Section 10. (1) The Executive Committee shall consist of, besides the President and Vice-President of the Council, seven members who shall be elected by the Council from amongst its members.

(2) and (3) No alteration.

(4) No business at any meeting of the Executive Committee shall be conducted unless at least five members are present.

PROVINCIAL COMMITTEES.

Section 11. (1) The Provincial Committee shall consist of the following members, *viz.*:

(*a*) The Member of the Provincial Medical Council, wherever such a Council is constituted.

(*b*) the members of the Council elected by:

(1) each Indian university,

(2) the medical practitioners,

(3) the Licentiates, and

(4) the members nominated to the Council by the Governor-General-in-Council from the province, if any, under sub-clauses (*c*), (*d*) and (*e*) of Section 3 (1).

(2) The Registrar of a Provincial Medical Council shall be the Secretary of the Provincial Committee of the Council

(3) No alteration.

THE REGISTRAR.

Section 12. No alteration.

PROCEDURE FOR ENROLMENT.

Section 13. (1) Omit the words " Secretary... ......Regulations " from the 4th line to the end of the paragraph and omit the 1st proviso and after the words " made to " in the 4th line add the words " the Registrar".

After the word " Registrar " add " The applicant will mention in the application the name of the Province in which he is residing and the Registrar shall dispose of it in accordance with the provisions of the Act and the Regulation and inform the Provincial Committee of such action".

QUALIFICATIONS FOR ENROLMENT.

Section 14. No alteration.

Addition.

(*a*) *Publication of the Register.*—The Council shall in every year cause to be printed, published and sold a correct Register of the names in alphabetical order according to the surnames, with their respective residences and qualifications conferred by any medical institution or university with the dates thereof of all persons appearing on the Register as existing on the 1st day of January in every year, and such a Register shall be called the Indian Medical Register.

ERASURE OF NAMES OF PERSONS GUILTY OF IMPROPER CONDUCT.

Section 15. (1) If it appears to a Provincial Committee of the Council that there is a reasonable ground to believe that any person enrolled on the Register and residing in the province for which such Committee is constituted has been convicted, either in His Majesty's possessions or elsewhere of a criminal offence implying a defect of character which unfits him to be a medical practitioner, or that he has been held guilty of infamous conduct in a professional respect, whether such offence or improper conduct has been committed before or after the enrolment of such persons or that he has been deprived of his recognised medical qualifications by the medical institution which granted them, the Committee may, after three months' notice served personally or sent by registered post to the last known address of such person, hear and consider the matter, and, if satisfied that such person has been so convicted, or has been held guilty of such improper conduct or has been so deprived shall either reprimand or suspend judgment or order erasure of the name of the person concerned, as the Committee may deem fit, and in the latter case, shall make a report to that effect to the Registrar General, who shall erase the name of such person from the Register:

Provided that—

(*i*) Same, except in line 9, substitute "Registrar General" for "Registrar."

RE-ENROLMENT AFTER ERASURE FROM THE REGISTER.

Section 16. No alteration.

OTHER AMENDMENTS OF THE REGISTER.

Section 17. No alteration.

RECOGNITION OF MEDICAL QUALIFICATIONS GRANTED BY MEDICAL INSTITUTIONS IN INDIA.

Section 18. (1) The medical qualifications granted by any statutory Indian University having a Medical Faculty which are included in the First Schedule shall be recognised medical qualifications for the purposes of this Act.

(2) A medical institution in India which grants medical qualification not included in the First Schedule may apply to the Secretary of the Provincial Committee in the province in which the institution is situated (and in a province where no such Committee is so framed, to the Registrar) who shall, after making such enquiries as the Provincial Committee, or in the case of the province with no Committee, as the Council may direct, forward the same to the Registrar of the Council with the remarks of the Provincial Committee concerned. The Council, if it thinks fit, will recommend the recognition of the said medical institution to the Governor-General-in-Council and the Governor-General-in-Council may by notification in the Gazette of India amend the Frst Schedule so as to include such qualifications therein.

(3) No alteration.

Addition.

(4) In case of any university or medical institution not being recognised by the Council for any reason, an appeal shall lie to the Governor-General-in-Council.

RECOGNITION OF MEDICAL QUALIFICATIONS GRANTED BY MEDICAL INSTITUTIONS OUTSIDE INDIA.

Section 19. (1) The medical qualifications now granted by medical institu ions in countries outside India shall be declared recognised medical qualifications under the Act, as soon as the Governor-General-in-Council is satisfied on the report of the Indian Medical Council that the registering authorities of such countries are prepared to enter into schemes of reciprocity, as regards enrolment and registration of medical practitioners, with the Indian Medical Council. A list of such medical qualifications shall, by notification in the Gazette of India, be included in the Second Schedule. Such notification may also direct that an entry shall be made in the Second Schedule, declaring that such be a recognised medical qualification only when granted after a specified date.

(2) No alteration.

(3) Omit this paragraph.

(4) to be re-numbered as (3) and will be as follows:

"The Governor-General-in-Council may, on the report of the Council, by notification in the Gazette of India, amend the Second Schedule so as to delete any medical qualification therefrom."

Addition.

(4) In the case of Indian students proceeding for medical education to a foreign country outside India before the establishment of the Indian Medical Council and obtaining a degree or diploma in that country, they may be enrolled in the Register even though the reciprocal arrangements mentioned in sub-section (2) may not exist with that country provided the qualification is obtained after examination, that would entitle the holder thereof to practise as a medical practitioner in that country in which it was obtained, and that it indicates a standard of profes.ional education not lower than that prescribed by the Indian Medical Council for purposes of registration in the Indian Medical Register.

(NEW SECTION) PRIVILEGES OF REGISTERED PERSONS.

Section 20. Notwithstanding anything contained in any enactment, rule, regulation, bye-law, or order to the contrary;

(1) After the enactment of this Act, the expression 'legally qualified Medical Practitioners' or 'duly qualified Medical Practitioner' or any expression importing a person recognised by law as a medical practitioner or member of the medical profession, shall when used in any Acts of the Central or Provincial Legislatures mean a medical practitioner registered under this Act, or the Provincial Medical Acts till further amended under Section of this Act.

(2) A registered practitioner shall be entitled to recover in due course of law any expenses or fees which he may be entitled.

(3) No certificate required by any Act, now in force or that may hereafter be passed, from any medical practitioner or medical officer shall be valid unless the person signing the same shall have been registered under this Act or under Provincial Medical Acts.

(4) After enactment of this Act, no person shall hold any appointment as a

Physician, Surgeon, or other Medical Officer in the Civil, Military, Naval or Air Force Services in India or any Dispensary or Hospital or Lying-in-Hospital or Infirmary not supported entirely by voluntary contributions, or any public establishment, body or institution or as a Medical Officer of Health or as a Medical Officer in vessels plying in Indian waters, unless he be registered under this Act or the Provincial Medical Acts.

(5) Notwithstanding anything in any other Law for the time being in force, every person who shall be registered under this Act shall be exempt if he so desires from serving on all juries and inquests whatsoever.

Sections 20, 21, 22, 23, 24 and 25 to be re-numbered 21, 22, 23, 24, 25 and 26.

POWER TO REQUIRE INFORMATION AS TO COURSES OF STUDY AND EXAMINATIONS.

Section 21. (New Section) (Section 20 of the Bill). No alternation.

INSPECTION OF EXAMINATIONS.

Section 22. (New Section) (Section 21 of the Bill).

(1) Substitute "The Executive Committee" by "the Council" and add the words "and visitors" after the word "Inspector."

(2) Add the words "such examination" after the words "in regard to" in the sixth line of this clause.

(3) Delete the words "to the Governor-General-in-Council" in the last sentence of the clause and substitute "to the Council. The Council shall, after considering such reports, send them to the Governor-General-in-Council with its recommendation."

WITHDRAWAL OF RECOGNITION.

Section 23. (New Section) (Section 22 of the Bill).

(1) No alternation.

(2) In place of "Local Government of the province" substitute "Provincial Committee where one is established" and in the fifth line of this sub-section in place of "Local Government" the words "the Provincial Committee where one is established" be substituted and in the last line of the sub-section in place of "Local Government" the word "Committee" be substituted.

(3) In place of "Local Government" the words "Provincial Committee where one is established" be substituted and in place of the words "Governor-General-in-Council" the following be substituted:

"The Council, then will forward to the Governor-General-in-Council its recommendations."

In sub-section (4) after the words "direct that" the following be inserted: "the medical qualification granted by the institution be not regarded as a recognised medical qualification and that." At the end of sub-section (4) the following be added "provided that the Governor-General-in-Council may on a further representation by the Council or on a representation from the institution revoke such direction."

Addition.

(5) During the continuance of such direction the institution to which it it relates shall cease to have a representation (if any) on the Council.

POWER TO MAKE REGULATIONS.

Section 24. (New Section) (Section 23 of the Bill).

Sub-section (1)—clause (*l*) and (*m*) be added :—Clause (*l*) Mode of election under Section 3, sub-section (1), clauses (*b*), (*c*), (*d*) and (*e*).

Clause (*m*) providing for penalties to be enforced in cases of false representation of any kind made by an applicant for registration in the register.

Sub-section (*ii*) after the words "Governor-General-in-Council" add the following : "Provided that, no permanent appointment, or commitments shall be made by the Governor-General-in-Counccial.".

INFORMATION TO BE FURNISHED BY COUNCIL AND PUBLICATION THEREOF.

Section 25. (New) Section (Section 24 of the Bill) No alteration.

COMMISSIONS OF INQUIRY.

Section 26. (New Section) (Section 25 of the Bill).

(1) Whenever it is made to appear to the Governor General-in-Council that the Council is not complying with any of the provisions of this Act, the Governor-General-in Council may notify the particulars of such alleged default to the Council, and if the Council fails to remedy such defaults within such time as may be fixed by the Governor-General-in-Council in this behalf the Governor-General-in-Council may for the purpose of remedying such default refer the particulars of the complaint to a Commission of Inquiry......its opinion necessary.

(2) and (3). No alteration.

(NEW SECTION.)

Section 27. In consequence of the enactment of this Act and in consonance with its provisions, an All-India Provincial Medical Councils Consolidating Act shall be passed for the purpose of amending the existing Provincial Medical Acts and Standardisation of Provisions relating to Medical education and registration throughout India.

(NEW SECTION.)

Section 28. The Indian Medical Council shall cause to be published under their direction a book containing a list of medicines and compounds, and the manner of preparing them, together with the true weights and measures by which they are to be prepared and mixed, and containing such other matter and things relating thereto as the Council shall think fit, to be called "The Indian Pharmacopoeia" and the Council shall cause to be altered, amended, and re-published such Pharmacopoeia as often as they shall deem it necessary.

THE FIRST SCHEDULE.

Add "Patna University, Andhra University and Rangoon University" in the first column and "Bachelor of Medicine" and "M. B." against each of the above universities and in the second and third columns respectively.

Add a Third Schedule.

THE THIRD SCHEDULE.

(See Section 18).

Recognised qualifications, and certificates, other than those mentioned in the First and Second Schedules.

(1) Fellow, Member and Licentiate of the College of Physicians and Surgeons of Bombay.

Fellow, Member and Licentiate of the State Medical Faculty of Bengal.

Fellow, Member and Licentiate of the State Medical Faculty of the Punjab.

Licentiate and Apothecary of the Board of Examiners, Medical College, Madras.

Licentiate of the State Board of Medical Examinations, United Provinces.

Licentiate of the Behar and Orissa Medical Examination Board.

Licentiate of the Burma Medical Examination Board.

Licentiate of Central Provinces Medical Examination Board.

Licentiate of the Assam Medical Examination Board.

(2) Any person trained in a Government Medical College or School who holds a diploma or a certificate granted by Government declaring him to be qualified to practise Medicine, Surgery and Midwifery, or to be qualified for the duties of a Military Assistant Surgeon, Hospital Assistant or Sub-Assistant Surgeon; or any person who holds a diploma or certificate to the same effect, granted by the King Edward Hospital Medical School at Indore, or the Medical School, Hyderabad (Deccan).

A Presurgical Soliloquy.

To cut or not to cut: that is the question:
Whether 'tis wiser for an o'er racked frame to suffer
The tortures of outrageous 'pendicitis,
Or to take knife against the surly monster;
And by curtailing, kill it. To cut, to slash:
What more? And by that slash to put on end
To pain and wipe forever off the slate
That dreaded organ: 'tis a consummation
Devoutly to be wished. To cut, to slash:
To slash, perchance to death: aye there is the rub!
For in that slash so keen may lie the power
To make us shuffle off this mortal coil
Our too, too solid flesh might melt,
And we might fain resume existence, when
We had it not. Doctors and weilder's of
The knife protect us! Till the damn'd thing lies
At rest in alcohol—and then we'll thank thee!

(*Pacific Pharmacist*).

Truths about Leprosy.

1. As weed comes from weed, so leprosy comes from leprosy.

2. Weeds grow in an unclean yard. Leprosy develops in an unclean body.

3. The body is made unclean by bad habits, unbalanced or deficient diet, lack of exercise, venereal diseases, and debilitating illness such as malaria, hookworm, chronic dysentery, etc.

4. You may not be able to avoid a leper, but it is in your power to get rid of the factors that would make your body unclean.

5. Leprosy is not hereditary but spreads by contact, by joint use of the bed of a positive leper, by living in the same house with him, and by close association with him.

6. Weeds do not possess seeds in all stages; so also with leprosy. In the incipient stage it is not generally dangerous; but years later, when it has fully developed countless seeds (the germs), it is dangerous to others and has become difficult to cure.

7. Therefore, uproot leprosy in the very beginning.

8. A small reddish or pale patch or "pano blanco" with no sensation or that does not yield to the ordinary ointments and cures, or a thickened painful nerve should always be suspected as a sign of leprosy in the initial stage.

9. Leprosy is practically 100 per cent curable at this stage.

10. During the last five years, over one thousand people have already been cured at Culion and at the San Lazaro Hospital, Manila.

11. Leprosy was stamped out in Europe when science was in its infancy. Today, with the aid of modern science, it is possible to stamp it out from the Philippines if the people here wish to do so.